DOCUMENT RESUME

ED 182 623 CG 014 108

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TITLE The Role of the Spouse in the Treatment of Alcoholism.
PUB DATE Sep 79
NOTE 14p.; Paper presented at the Annual Convention of the American Psychological Association (87th, New York, NY, September 1-5, 1979)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Alcoholism; *Behavior Patterns; Expectation; *Intervention; Models; *Role Theory; *Spouses; Therapy
IDENTIFIERS *Behavior Modification

ABSTRACT

The role of the spouse in both the etiology and the maintenance of alcoholism has been focussed on by theoreticians of various persuasions, including psychoanalytic, behavioral, sociological and family systems. These models, focussing on individual and interactional components of alcoholism, have generated a variety of treatment interventions which involve the spouse in the treatment process. At least three case reports and three controlled studies of concurrent (spouses both in separate therapies) therapy for the alcoholic and spouse have suggested that this approach improves treatment outcome over individual approaches. Numerous reports of conjoint (spouses meeting together with a therapist) treatment (five case studies, five controlled studies) have also found spouse involved treatment to be more effective than individual treatment. A behavioral systems model of alcoholism treatment is discussed. In this model, a functional analysis of drinking behavior breaks down antecedents and consequences of drinking into individual components, spouse components and marital components. Treatment then focuses on each of these aspects sequentially. Each phase of treatment is described in detail. Case illustrations are provided, and a planned controlled evaluation is briefly described. (Author/BMW)

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THE ROLE OF THE SPOUSE IN THE TREATMENT OF ALCOHOLISM

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Paper presented at a symposium on Couples Approaches to Health Behaviors at the Annual Meeting of the American Psychological Association, New York City, New York, September, 1979.

CG 014108

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The other papers on this symposium have presented data on involving the spouse in behavioral treatment programs for obesity and hypertension. The focus of this presentation will be somewhat different, in that I will be discussing two different areas of literature--the literature on spouse involved alcoholism treatment and the literature on behavioral alcoholism treatment, and then will present a theoretical model which we have developed which integrates these two separate literatures. I will then discuss treatment implications of this model. We currently have a three year study underway to test these treatments as well as some of the theoretical implications of the model.

The history of alcoholism models and alcoholism treatment has been characterized by a gradual shift in emphasis from a focus on the individual exhibiting problematic drinking, to a focus on <u>two</u> persons with individual problems (the alcoholic and spouse), and finally to a focus on a two person or larger system in which alcohol is a problem.

Early individual models of alcoholism were of one of three types--models based on psychodynamic principles, models based on learning principles, or models based on the disease concept of alcoholism. All three models posited a "fatal flaw" within the alcoholic, and the alcoholism was viewed strictly as an individual problem. This "fatal flaw" took on different forms, depending on the model. These models are not being reviewed here in great detail, but it is important to note that the evidence for these early unifactor individual models is not good.

The concept that the spouse was somehow responsible for the alcoholism began to emerge in the late 1930's and became more predominant by the early 1950's. The thrust of this period was on the troubled wife of the poor helpless alcoholic. The alcoholic's spouse described as being riddled by neurotic conflicts, unable to maintain her own psychological well-being if her husband

became sober, and ravaged by sexual fears, dependency conflicts, poorly controlled agressive impulses, and a desire to dominate a weakened male. She was seen as grossly psychologically disturbed, and was expected to decompensate if her husband became sober.

Repeated attempts have been made to identify such enduring psychological problems among the wives of alcoholics. While some researchers have been able to demonstrate increased symptoms of psychological disturbance among the wives of actively drinking alcoholics, others have been unable to show that these women perform any differently than the average woman on a host of psychological tests. Furthermore some researchers have found that these wives show a marked decrease in their psychological problems if their alcoholic mate stops drinking, suggesting that their difficulties may be a result of the drinking rather than a cause.

With the development of Al-Anon, and the pioneering work of Joan Jackson, Kate Kogan and their associates in the 1950's and 1960's, theorists began to examine the separate behaviors of the alcoholic and spouse. In this view, each member of the couple had individual problems, which needed separate treatment, in order for the alcoholic to remain sober and the family to reconstitute.

Based on this model, a host of programs developed methods of concurrent treatment for the alcoholic and spouse. While the alcoholic was receiving treatment for his or her alcholism, the mate was being seen separately, usually by a separate therapist, to examine her own role in the drinking, and to learn alternate ways of responding to drinking related situations. This is still a popular alcoholism treatment model. Attendance at Alcoholics Anonymous for the alcoholic and Al-Anon for the family is one of the most popular, although unstudied ways of delivering this form of treatment. Numerous clinical and controlled evaluations have found that having a cooperative spouse participate in concurrent treatment improves the chances for the alcoholic to

decrease or stop his drinking. However no technology for changing spouse behaviors has been developed. Thus, the concurrent model and data based on it strongly suggest that involving the spouse in treatment in some way improves the probability of positive treatment outcome.

In the 1970's the focus shifted to the system, in which the family as a unit was seen as bearing the responsibility for any individual member's symptomatic behavior. Thus, rather than describing alcoholism as the result of the individual problems of either the alcoholic or the spouse, the focus has instead been on the interactive nature of alcohol and marital problems. Marital system malfunctioning results in alcohol problems which in turn result in increased marital strife and so ad infinitum. The etiology of the alcohol problem may be unknown, but the drinking behavior is maintained by the homeostatic mechanisms of the family system which has incorporated the role of alcoholic into it.

There have been several case reports and several controlled studies focussed on the treatment of the marital problems within the family system rather than on alcoholism per se. As a group, these studies have found moderate improvements in drinking outcomes when a marital or family approach has been utilized, as opposed to an individual approach. Most of these controlled studies, however, have methodological weaknesses that limit the definitiveness of their findings. Only two studies randomly assigned subjects to groups, equalized amount of treatment across groups and used independent measures of outcome. Both found the marital treatment to be superior. Thus, these studies as a group suggest that marital treatment significantly improves alcoholism treatment outcome, but this conclusion must be tempered by the weakness of some of the studies.

The other major trend in the alcoholism field which I want to describe is the increasing interest in behavioral treatments of alcoholism. Behavioral

treatments for alcohol problems are based on a functional analysis of drinking behavior, involving consideration of antecedents, organismic variables, characteristics of the response, and consequences.

A variety of behavioral treatment programs have been developed based on a behavioral analysis of drinking. Programs have focussed on one treatment, such as electrical or chemical aversion therapy, BAL discrimination training, or systematic desensitization, or, more recently, have utilized broad spectrum behavioral approaches, including skills training, confrontation, contracting, controlled drinking training and community reinforcement. Many of the broad spectrum programs have reported impressive success rates.

Considering the two major trends in the alcoholism field which I have discussed, the individual-spouse-system trend and the behavioral trend, it is possible to orthogonally cross these to come up with a behavioral-system model of alcohol problems. (See Figure 1.)

Using this model, the first system is the individual one. For now, I am subsuming several subsystems under the individual system, including the individual, job, friend, "drinking buddy" and family of origin subsystems. In a "final" matrix model, these would be considered separately, but since there are essentially no data in these now, I want to include them here but underscore their importance and lack of study. Antecedents in the individual system include times of the day (such as after work or just after children leave for school), settings (such as weddings or business luncheons), visual cues (such as the sight of beer or seeing a favorite drinking haunt), interpersonal stresses, activities habitually associated with drinking, job stresses, failure in problem solving situations, being pressured to drink. Organismic variables mediating the drinking response include physiological states, expectation of relief from anxiety and/or depression, expectations of other positive consequences of drinking, expectations that alternative means of

obtaining reinforcers are unavailable, expectations of loss of control after initial drinking, feelings of anxiety, depression or anger.

Characteristics of the drinking response which have been studied have included rate of drinking, frequency of drinking, magnitude of drinking and pervasiveness.

Consequences hypothesized to maintain drinking behavior include lack of awareness of physiological cues associated with low or moderate drinking, avoidance of or decrease in withdrawal symptoms; reduction in depression and anxiety in women; avoidance of requirements to fulfill social roles; social interpersonal attention; peer group acceptance, increased social interaction and assertion; or "forgetting." Most of the best known behavioral treatment studies such as Sobells, Wm. Miller, and Vogler's groups developed treatments based on the individual component of this model.

The second behavioral system revolves around the spouse. These antecedents include the many behaviors which spouses engage in which are intended to control the drinking, but often instead actually cue further drinking. For example, nagging the alcoholic to cut down on drinking, hiding liquor or throwing it away, taking control of checkbook and car keys, questioning the person on their behavior or threating all may actually trigger further drinking. Right now we know nothing about organismic variables in this system or the relationship between response characteristics and these types of antecedent stimuli. Drinking related spouse consequences include increased spouse attention contingent on drinking, sympathy, or protection from the consequences of the drinking (covering at work, doing undone chores, etc.) Only one behavioral study has focussed exclusively on spouse behavior. The results were inconclusive because of methodological problems in the study. However, Hunt and Axrin instructed spouses, as well as employers and friends, to provide a time out from reinforcement to alcoholic subjects when they

drank, and found these combined procedures to be more effective than traditional state hospital treatment. The spouse component was only one component, however, in a multifaceted treatment program. In a case report, Miller reported on a contracting procedure with an alcoholic couple, in which the spouse contracted to decrease nagging behaviors which cued drinking. It is clear that scant attention has been paid in the behavioral literature to training the spouse to modify his/her alcohol related behaviors.

The third set of antecedents and consequences of drinking are marital. Data suggest that alcoholic couples have poor communication and problem solving skills, that they exchange positives at a low rate, and that they have evolved a mode of interaction that involves attempts to control each other coercively, such as through threats or nagging. As the aversive situation has escalated over the years, communication has become more ambiguous, vague and inconsistent. As a result, these couples are unable to resolve problems, and a large backlog of problems has accumulated. In an alcoholic couple, when one of these problem areas arises, the conflict may result in drinking. Again no attention has been paid to the role of mediating events, in this system or to the effects of marital antecedents on the actual drinking response. The consequences of the drinking may be to avoid the problem, may be an increase in assertive or agressive responses on the part of the alcoholic, the alcoholic's rate of verbal output may increase, or one or both members of the couple may markedly change their behavior so that the problem is temporarily resolved. For example, a couple who is unable to be tender and affectionate when the alcoholic is sober, may more easily express feelings and caring when the alcoholic drinks. The drinking may also become a cue for marital conflict or for spouse cueing behaviors, which result in further drinking, and so on. Behavioral studies are scant in this area. One controlled study found behavioral marital therapy more effective than individual approaches with an

outpatient population and some case reports have also described behavioral marital therapy with alcoholic couples.

Thus, a behavioral analysis of drinking separates the three approaches to alcoholism treatment that have been utilized: The individual focus, the focus on changes in each partner related to drinking, and changes in the marital interaction system. I should note in passing here that I recently reviewed a large number of recent studies on interactions in alcoholic couples and on couples behaviors and treatment outcome and studies deriving from a host of theoretical frameworks appear to be consistent with this model.

The implications for treatment using this matrix analysis are myriad. Treatment should proceed with a functional analysis of the relationships between the drinking and the three areas described above. Questions would have to be raised during the assessment about which system is most powerful in maintaining the drinking, and interventions would then be directed at the most powerful system or systems.

I will now briefly discuss some of the potential treatments derived from this model, and conclude with some of the clinical and research questions which we have about this model.

The first area of treatment interventions, focussed on the individual system, does not need to be addressed in great detail here. Many behavioral treatment programs have developed and tested this component of the model with good success.

The second component of treatment revolves around interventions directed at spouse behaviors. The goals of this part of treatment are to: (1) decrease cueing behaviors for drinking, (2) increase provision of reinforcers for non-drinking, and (3) increase extinction responses for drinking. To decrease cueing behavior, several procedures can be used. For example, the spouse first needs to learn the contingency relationship between the cueing behaviors

and the drinking. In order to do this, a discussion of drinking episodes can occur in which the alcoholic member gives the spouse feedback about the effects these behaviors have on the drinking, and also by having the spouse record over a one to two week period his or her own behavior, the drinking, and the drinking impulses of the alcoholic spouse and then identifying the functional relationships among these. Spouses can be taught to decrease cueing and increase more appropriate responses. For example, they can use problem solving techniques to generate possible alternative solutions, and then can practice some of these behaviors in the therapy sessions. Social skills training also may be helpful at this point to teach spouses verbal behaviors alternate to nagging and questioning of the alcoholic. Therapists may model these responses and the spouse can then practice appropriately expressing feelings about drinking rather than the nagging behavior. The alcoholic spouse can also provide feedback about the effects of these alternate responses on her or her drinking impulses.

Another technique that can be helpful in decreasing cueing behavior is teaching spouses relaxation techniques, especially when they have a great deal of anxiety associated with things like the drinking partner being late. Relaxation procedures can be employed to decrease anxiety, which may be an antecedent to some of the cueing behaviors. Covert rehearsal procedures can be used as adjuncts to role playing to help spouses practice the implementation of the alternate behaviors, and covert sensitization or covert reinforcement can also be used.

To increase the provision of positive reinforcers for nondrinking and to increase extinction responses to drinking, the first step that is necessary is for the spouse to again be aware of the contingency relationships, which can be done through the procedures just described. Couples then discuss what kinds of positive responses the spouse could give to the alcoholic for sober

behavior, and for implementation of alternate responses in drinking situations. Identification of reinforcing responses, role playing rehearsal within the sessions, and assignment of these behaviors as homework are the most usual procedures to be used for this part of the treatment. The results of these changes are then evaluated by examining records of daily drinking and drinking urges.

To increase extinction behaviors for drinking, the spouses need to be introduced to the necessity of this, and can brainstorm possible alternate solutions to such situations as the alcoholic mate asking them to call the boss when they do not want to go to work because they are hung over, and then role playing these responses with the therapist or with the spouse within the session.

The third aspect of the treatment derived from this theoretical model involves behavioral marital treatment. The goals of this part of the treatment are to (1) increase the overall level of rewardingness in the relationship, (2) teach communication skills which will both increase the rewardingness of the relationship and decrease the frequency of aversive and coercive interactions which are presumed to function as antecedents to drinking and (3) to teach problem solving and contingency management or contracting skills in order to decrease the number of problematic areas in the relationship, thereby decreasing the number of antecedents to drinking. The kinds of treatment procedures that are used are those that are used in behavioral marital treatment for other kinds of marital problems. This involves a variety of techniques to increase rewardingness, such as love days, identifying and practicing giving compliments and other kinds of positive exchanges, identifying recreational activities in which they can participate together which are enjoyable. In teaching communication skills, we use fairly standard behavioral training models, including teaching the skills of objectification, empathy and support, expression of positive and negative feelings, problem solving, and behavioral contracting.

This discussion gives you an overview of our model and the treatments derived from it. We have many clinical, theoretical and treatment outcome questions about it. For example:

--How much intervention is necessary? If the drinking behavior changes, will there be subsequent improvements in the spouse and marital systems? This could well be so if the drinking cued these behaviors, which in turn cued drinking.

--If more than one of these three behavioral systems is addressed in treatment, is there an optimal order of sequence for treatments? Many of the marital treatment outcome studies start with a sober (detoxified or treated) alcoholic. Is it necessary to decrease the drinking first, before addressing spouse changes?

--How do age, ethnic group, sex, SES, severity of alcohol problems interact with this model? It may be that in certain groups, one of the systems is so much more powerful than the others that it would be essential to direct most of treatment to that system.

--How do this model and the treatments suggested from it interact with alternate drinking goals of abstinence versus reduced drinking?

--How can we predict, based on initial assessment, which systems are most important to intervene in?

These questions are only a subsample of the kinds of unanswered questions about treatment implementation. The relative effectiveness of the treatments is itself unknown, and that is what we are currently studying.

As I stated at the beginning of this talk, the state of the field in couples approaches to the treatment of alcoholism, and especially behavioral spouse involved treatment for alcohol problems is really very young. We have data from our own work and the work of other researchers suggesting that involving the spouse in treatment will significantly increase the likelihood

of positive treatment outcome. We now have a theoretical model which has some good empirical support, from basic and applied studies and which has clear implications for treatment procedures. We are now in the process of testing these treatment procedures, and doing further testing of the model upon which they are based.

FIGURE 1

BEHAVIORAL SYSTEMS MATRIX

	ANTECEDENT	ORGANISM	DRINKING RESPONSE	CONSEQUENCE
INDIVIDUAL	time settings visual cues interpersonal stresses activities job stresses pressure to drink drinking buddies	physiological states expectancies re positive consequences expectancies re loss of control negative emotions negative self-statements	rate frequency magnitude pervasiveness	lack of negative physiological feedback decrease or avoid withdrawal decreased anxiety and depression avoidance of social roles attention peer group acceptance increase social interaction increase assertion forgetting
SPOUSE	control behaviors nagging re drinking questioning re behavior	?	?	attention sympathy protection from negative consequences spouse assuming responsibilities
MARITAL	poor communication attempts at coercion problem areas	?	?	avoid problem increased assertion increased verbal output temporary resolution